Impact of the Sierra Health Foundation's Clinic Capacity Building Program:

Final Evaluation Report

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Center for Community Health and Evaluation

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Executive Summary

Background

Sierra Health Foundation (Sierra Health) launched the Clinic Capacity Building Program in 2013 as part of the Sacramento Region Health Care Partnership. The goal of the Clinic Capacity Building Program was to respond to the anticipated growth in demand (i.e., number of patients) created by the implementation of the Affordable Care Act by strengthening community health centers' administrative and operational capacity. The program aimed to improve clinic leadership, care quality and financial sustainability, thereby increasing the number of high performing Federally Qualified Health Centers in the region.

In May 2013, nine community health centers serving El Dorado, Placer, Sacramento, and Yolo Counties participated in the planning and assessment phase. In October 2013, Sierra Health awarded $1.4 million in implementation grant funding to five of these community health centers: Cares Community Health, Chapa-De Indian Health Program, Elica Health Centers, WellSpace Health, and Winters Healthcare. Each community health center received a two-year grant of up to $300,000 to implement changes to increase clinic capacity and improve quality and coordination of patient care in the Sacramento region. In addition to grant funding, the implementation phase included training and opportunities for peer learning and exchange through the Safety Net Learning Institute (co-sponsored by local health systems), CEO luncheons and Board receptions.

In July 2014, Sierra Health contracted with the Center for Community Health and Evaluation (CCHE) to evaluate the effectiveness of its Clinic Capacity Building Program. The goal of the evaluation was to assess the effectiveness of the Clinic Capacity Building program and contribution of the program to changes in capacity among the five grantees. This is the Executive Summary of the final evaluation report, which was submitted to Sierra Health in December 2015.

Capacity Building Accomplishments

Grantees indicated that funding provided general operating-like support. This funding gave them the flexibility to undertake strategic priorities to respond to increased demand created by health care reform and the expansion of Medi-Cal. During the past two years, all health centers served more patients, expanded their workforce, increased clinic efficiencies, and innovated around provision of care. Health centers reported accomplishments in six areas:

Delivering care differently: Health centers implemented new models for providing care to their patients. They focused on becoming Patient-Centered Medical Homes and implemented components of team-based and integrated care delivery.

Improving clinic efficiency: Health centers worked to maximize the use of existing capacity. Some health centers reported decreases in unfilled appointment rates (missed opportunities) and/or cycle time, which indicated greater efficiency.

Increasing supply of appointments: Health centers expanded the number of appointments available, mostly through adding exam rooms or hiring more clinical staff. While health centers successfully expanded, the supply of appointments continued to be inadequate to meet demand.

Strengthening governance and operations: Health centers strengthened internal processes and operations, which resulted in increased financial stability and a higher proportion of patient net service revenue.

Driving quality improvement with data: Health centers recognized the importance of access to high quality data to drive their improvement efforts. They worked to maximize the use of their health information technology, purchased system add-ons to increase functionality, used reporting tools to make data more accessible, and hired data analytics staff to increase clinic capacity.

Engaging patients in care: Health centers engaged current and potential patients through monitoring patient satisfaction, implementing patient-centered care models, and doing outreach to both reach prospective patients and as well as to provide convenient care in the community.

Program Participation

Grantees appreciated that the grant provided them with dedicated time, funding and a structure for capacity building and quality improvement. They indicated that the additional support provided through the grant—Safety Net Learning Institute, CEO luncheons, and Board receptions—added value and promoted collaboration. Yet, they also expressed some difficulty devoting the time for the "right people" to participate in the midst of all of the changes occurring in their health centers.

Challenges

Grantee leadership demonstrated commitment to growth and sustainability, while trying to address challenges of aligning workforce, patient demand, and infrastructure limitations. The dynamics of trying to align supply and demand was further complicated by the constraints of unfamiliar and often unresponsive regulatory processes. Although all health centers increased their capacity and were serving greater numbers of patients, leaders noted a myriad of challenges their organizations faced in the process. Challenges included:

- Recruiting and retaining a qualified workforce
- Managing complex new patients
- Managing and leading change
- Navigating uncharted territory and regulatory roadblocks
- Remodeling and expanding clinic space
- Adopting new technology
- Leveraging opportunities for collaboration among safety net partners in the region

Considerations for Sacramento's Safety Net

In Sacramento, the demand for health care services continued to outweigh supply. Grantees and health system representatives perceived the lack of collaboration among safety net providers to be a significant challenge preventing them from effectively meeting demand. Both community health centers and health systems recognized that the health centers needed a sustainable support structure and a neutral convener to promote collaboration. A clinic consortium or convener would be beneficial to:

- Provide leadership and a vision for a regional safety net system
- Provide forums for collaboration, partnership and peer exchange
- Create an infrastructure to support ongoing capacity building at the clinics
- Support and develop clinic leadership

The health systems operating in the region—Dignity, Kaiser Permanente, Sutter, and UC Davis—saw themselves as partners in strengthening the safety net; however, they had different interests and processes for supporting the community health centers in the region. There was some coordination among health systems and other local funders—like Sierra Health—but health system representatives reported that consistent and reliable communication among funders was lacking and the region would benefit from a more coordinated funding approach. The health systems saw Sierra Health as a key player in the region and an important partner to continue strengthening the capacity of the safety net.

I. Background

Sierra Health Foundation (Sierra Health) launched the Clinic Capacity Building Program in 2013 as part of the Sacramento Region Health Care Partnership, a coordinated philanthropic, non-profit provider and community clinic initiative to strengthen the health care safety net in the Sacramento region. The goal of the Clinic Capacity Building Program was to respond to the anticipated growth in demand (i.e., number of patients) created by the implementation of the Affordable Care Act (ACA) by strengthening community health centers' administrative and operational capacity. The program aimed to improve clinic leadership, care quality and financial sustainability, thereby increasing the number of high performing Federally Qualified Health Centers (FQHCs) in the region.

As FQHCs, community health centers are able to bill the federal government for supplemental funding for health, behavioral health, children's oral health, and other services. This provides a critical access point for underserved persons in the community, leverages federal funding, and provides a sustainable model for the health centers.

Sierra Health engaged the four non-profit health systems—Dignity Health, Sutter Health, Kaiser Permanente, and UC Davis Health System—as thought partners and advisors in the program. The health systems saw themselves as partners in strengthening the local safety net; however, they all played slightly different roles (e.g., direct in-patient and specialty care services, funding to community health centers, placement of residents, etc.). Representatives from the health systems' community benefit programs were advisors and sponsors of aspects of the Clinic Capacity Building Program (referred to in this report as "health system representatives").

In May 2013, Sierra Health awarded 3-month planning grants to nine community health centers serving El Dorado, Placer, Sacramento, and/or Yolo Counties. This planning phase informed the selection of five health centers to participate in the implementation phase in October 2013: Cares Community Health, Chapa-De Indian Health Program, Elica Health Centers, WellSpace Health, and Winters Healthcare.

Sierra Health awarded $1.4 million in grant funding during the implementation phase. Each community health center received a two-year grant of up to $300,000 to implement changes to increase clinic capacity, improve patient care and coordination in the Sacramento region. The health centers focused on six domains: governance and planning; community engagement and organizational leadership; patient experience and services; data-informed decision making; learning and training; and the Affordable Care Act (ACA) implementation. In addition to grant funding, the implementation phase included:

- Participation in the Safety Net Learning Institute (co-sponsored by health systems)
- Other peer learning/networking opportunities
- Access to coaches/consultants

The five health centers that received implementation funding had deep roots in their local communities, but four had only relatively recently received federal designation as a FQHC. This designation changed how care was delivered and the patient population served by these clinics. So while these were well-established organizations, four were relatively young FQHCs who were faced with managing extensive changes to meet the growing demand for services that resulted from Medi-Cal expansion and the implementation of the ACA.

In July 2014, Sierra Health contracted with the Center for Community Health and Evaluation (CCHE) to evaluate the effectiveness of its Clinic Capacity Building Program. The goal of the evaluation was to assess the effectiveness and contribution of the program to changes in clinic capacity among the five grantees. This report summarizes the results of the evaluation.

II. Methods

The evaluation was designed collaboratively with staff from Sierra Health to answer the following evaluation questions:

- To what extent has clinic capacity changed throughout the course of the program?
- What, if any, contribution did program participation have on changes to clinic capacity?
- To what extent have stakeholders' perceptions of the health centers changed?

To answer these questions, data collection methods were designed to collect information directly from grantees and review of available clinical data and programmatic materials. Data collection methods that informed this report are summarized below.

Data collection method	Purpose	Timing
Review of grant proposals and health center self-assessments	To orient the evaluation team to the health centers and identify sources of baseline data.	Summer 2014
Health center site visits with leadership and staff (annually)	To document changes in capacity and the impact of participating in this program from multiple perspectives within the health center.	November 2014 October 2015
Review of health center data	To update financial and operational metrics collected in the self-assessment.	December 2014 September 2015
Mid-year interviews with health center CEOs	To assess progress, identify challenges and needs for additional technical assistance.	March 2015
Review of grant reports to Sierra Health	To capture progress, accomplishments, and challenges.	Fall 2014 Fall 2015
Analysis/synthesis of post-event surveys and other satisfaction data	To assess satisfaction with the learning sessions and whether sessions that were more favorably rated had more of an impact on clinic changes.	Ongoing
Interviews with health system community benefit managers	To assess grantee progress in increasing capacity, identify challenges, explore unmet regional needs.	August 2015

Quantitative data from the health center data reports were analyzed using the quantitative software, R. Clinical measures relating to finances, staffing, access, and efficiency were analyzed for trends over the time period of grant funding. Qualitative data were analyzed using thematic analysis to code, categorize and identify themes in the data. The resulting themes were grouped into domains. This process was aided by the qualitative analysis software, Atlas.ti.

All data informing this report were obtained via self-report from grantees. Self-reported data are known to contain bias of various kinds, including positive response bias and differences in recall. Additionally, design and environmental factors make it difficult to attribute observed changes to Sierra Health's investments alone. Despite these limitations, the evaluation provided an in-depth examination of grantee progress related to this program.

III. Capacity building accomplishments

All five grantees reported increased capacity as a result of the investment of Sierra Health. Health center representatives indicated that the funding provided general operating-like support that allowed them flexibility to address strategic priorities for their health centers. Through the grant, health centers invested in strategic consultants, trainings, and technology. They also used the resources to offset patient revenue and pay for clinical staff time to focus on improvement efforts, and in some of the health centers, to recruit and train needed staff. This investment was significant for these health centers, four of which were fairly young FQHCs and all were rapidly growing to meet increasing demand for services.

Representatives from all grantees were able to identify accomplishments achieved as a result of the Sierra Health grant. Due to health care reform and the expansion of Medi-Cal, all clinics served more patients, expanded their workforce, improved clinic efficiencies, and innovated around the provision of care. The grant allowed health centers to make progress in six areas:

1. Delivering care differently
2. Improving clinic efficiency
3. Increasing supply of appointments
4. Strengthening governance and operations
5. Driving quality improvement with data
6. Engaging patients in care

These accomplishments are discussed more in the subsequent pages.

Given the significant changes in the health care environment, health centers undertook multiple improvement initiatives and changes in one area often cascaded into changes in other areas. For example, the potential to increase capacity through one change (e.g., adding exam rooms) was limited by other system elements that remain static (e.g., clinical workforce). The full potential of these accomplishments to increase capacity may not be fully experienced until other related constraints are addressed. As a result, the full impact of the program may continue to grow as health centers build on the work they did during the grant.

Health center leadership recognized that the improvements that they made resulted in a significant level of change within their organizations. To successfully manage these changes, leadership noted that having a supportive culture and buy-in from leadership, providers, and staff was critical. It was also important to ensure that members of their Board of Directors were aware of and supportive of the changes they were implementing.

Representatives from the major health system partners in the region (Dignity Health, Sutter Health, Kaiser Permanente, UC Davis Health System) agreed that the grantees had been successful at building capacity and growing during this two year period. While they highlighted many opportunities for continued improvement, they emphasized that the safety net clinics in the region had a deep understanding of the community they served and provided quality primary care services for their patients.

Delivering care differently

> "The process of becoming a PCMH helped expand our care to more patients."
>
> —COO, Grantee B

Most of the grantees responded to health care reform and increased service demands by deliberate shifts toward **patient-centered medical home** (PCMH) certification. While most of these clinics began the transition to PCMH prior to their grant, the grant allowed them to move forward with this multiple-stage process. The one health center that did not pursue PCMH certification made a decision to invest in other efforts to improve service delivery—including and expanding on many components of the PCMH model—rather than directly seek certification at this time.

> "All teams are active in caring for patients and communicating that to patients…so [the patient knows] there are more people than just their provider who they can access for information and care."
>
> —COO, Grantee D

Team-based care is a key element of the PCMH model of care and an aspect of Coleman Associate's Rapid DPI (Dramatic Process Improvement) interventions that three health centers implemented as part of their grant. For all health centers, care teams included at least a dyad of one provider and one medical assistant. Care teams at many health centers included other staff, such as: nurses, front desk staff, behavioral health providers, and referral coordinators.

Generally, care teams used daily team huddles—involving all members of the care team—to improve the flow of communication within the clinic and help teams anticipate patients' needs before they arrived. Engaging other staff, like referral coordinators, into their care team huddles helped ensure more effective follow-up with patients.

Another aspect of health centers' team-based care work, was to ensure that care team members—particularly medical assistants and nurses—were working at the top of their license. This freed up provider time by engaging more staff in direct patient care.

In addition to delivering care through a team approach, all health centers established mechanisms for **integrating service delivery**. Health centers focused these efforts on integrating behavioral and oral health services and reorganizing service delivery to provide within-visit access to pharmacy support, health education, social services and appointment management. These changes helped to more seamlessly meet the multiple needs of the patient in one visit.

> "It's more than just being co-located, you have to bring the silos together. Therapists have opened their schedules so they can see people immediately and de-escalate situations.[We're trying to figure out]…how to structure a therapist's day to make them available to primary care patients."
>
> —Administrator, Grantee E

All five health centers worked to improve **access to behavioral health** to respond to an increased demand for these services. Health centers approached integration of behavioral health differently, but all were working toward having behavioral health providers on staff and reducing barriers for patients to access these providers. Changes included: integrating behavioral health providers into care teams; integrating depression screening (PHQ-9) into the primary care visit; and changing schedules for behavioral health providers to ensure they were available to see people immediately, if needed. Health centers emphasized that providing behavioral health in this environment required a different model than in more traditional mental health departments. As one behavioral health provider

explained: *"…you won't have 12 cognitive behavioral therapy sessions with a patient. You need to assess what issue they are having and provide solutions that can help them function, sometimes only within 10 minutes. It's a quick and generalist approach, but it enables me to talk to patients in a non-traditional way so that they can get the care they need."*

Four health centers also provided **dental care** within their clinic and worked to further integrate it into their clinics. One health center specifically cross-trained the medical and dental front-desk staff in order to familiarize each department with how the other operates.

In addition to accessing services within the clinics, grantees recognized that many of their patients required more comprehensive **care management**, which included navigation to community resources. These support services took different forms at each of the health centers. Some health centers had lay health workers on staff to connect patients to resources, others provided assistance like taxi vouchers and bus passes, while still others had staff helping enroll eligible patients in benefits (e.g., Medi-Cal).

Empanelment, assigning a patient to a care team and scheduling their visits with that team, is also a PCMH best practice. Three health centers had an **empanelment rate** higher than 90% in 2015. Empanelment aims to improve continuity of care for patients. In 2015, four health centers reported on **continuity of care** rate, defined as the percentage of patient's annual visits that included their primary care provider. Continuity of care ranged from 25% to 90%, with an average of 65%. There was not a standard target for continuity of care among PCMHs, but to put the observed range of continuity of care within context, a study of 312 FQHCs found the average continuity of care rate to be 63% in 2009.[1]

Examples of the variety of approaches the grantees took to deliver care differently are summarized in the table below. More detailed "spotlights" are provided in the appendix.

Cares Community Health	Cares established itself as a PCMH, expanded clinic space and pharmacy, added mobile dental services, deployed Coleman's DPI, and reached out to non-HIV patients. To accommodate all of this new work, they are "*trying to build a campus.*" When plans are fully realized, Cares' original facility may become the cornerstone of a not-for-profit health care complex occupying a full city block with separate facilities for primary care, women's health, dental services, mental health counseling, a Federally-subsidized pharmacy, and space for community and education programs.
Chapa-De Indian Health	Chapa-De transformed its physical space by undergoing a major remodel completed early in 2015. The transformation was not only physical. Chapa-De leadership embraced radical change and with this grant implemented a conversion to an accredited PCMH offering primary medical care, behavioral health services, nutrition and health education, pediatrics, women's health services, dental care, orthodontia, psychiatry, optometry, and pharmacy services.
Elica Health Centers	Running out of clinic space and committed to the most vulnerable populations, Elica embraced a three-phase street medicine program to provide care while adding space in their brick-and-mortar facilities and opening a third clinic site. Delivering care differently for Elica meant disrupting and innovating from within. Elica's COO explained, "*What could be more disruptive and innovative than Health on Wheels?*"

[1] Perry, Rebecca et al. 'Examining The Impact Of Continuity Of Care On Medicare Payments In The Medical Home Context'. *Academy Health Annual Research Meeting*. Orlando, FL: RTI International, 2012. Web. 26 June 2015.

WellSpace Health	WellSpace Health focused on meeting needs across the metropolitan region. In 2015, six primary care sites received PCMH certification, signaling to the community that WellSpace Health was delivering care differently. Twelve regionally-distributed health centers integrated medical and behavioral health; WellSpace Health included evidence-based depression screening at intake and behavioral health care was provided within the patient visit. Some clinic sites offered pediatric dental care, women's health services, psychiatry and substance abuse counseling. WellSpace Health also operated rehabilitation treatment centers and community treatment sites and services.
Winters Healthcare	Winters Healthcare understood that successful strategies to provide integrated care to the sparse rural communities of western Yolo County were going to be different. After investigating several models, they embraced a system of care created to provide access to medical, dental, behavioral, traditional and health care support services by building trusting relationships: the Nuka System of Care, developed by Alaska's Southcentral Foundation and subsequently endorsed by the Institute for Healthcare Improvement and others at the forefront of transformative health care.

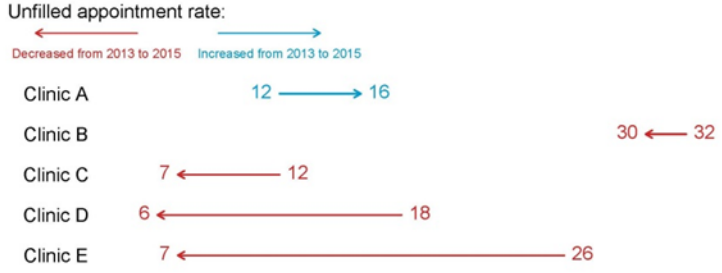
Improving clinic efficiency

> "To me, it's all about efficiency. If everyone is functioning at the top of their license, we see more people and have better quality and that's increased capacity."
>
> —CMO, Grantee B

All health centers experienced growth in the number of encounters and/or patients served.. During the funding period, growth ranged from a modest increase in monthly encounters in the smallest rural clinic with the smallest catchment area, to more than doubling patient volume through an aggressive approach to opening new clinics by another health center. Health centers attributed the increased number of patients to auto-assignment of new Medi-Cal and Covered California (the California state health benefit exchange) patients and relationships with inpatient health systems that discharge uninsured and Medi-Cal beneficiaries from the hospital or emergency room directly to these health centers. Because of this influx of new patients, health centers devoted grant resources to trying to maximize existing capacity and improve efficiencies to meet the demand of a growing patient population while pursuing long-term growth strategies.

Three health centers invested grant resources in practice coaching from Coleman Associates. All the health centers that engaged in Coleman's Rapid DPI interventions attributed gains in efficiency to it. However, changes in specific indicators of efficiency were neither exclusive to the clinics that engaged with Coleman nor uniform among those that did.

A key measure of efficiency tracked by health centers was missed opportunities (i.e., **unfilled appointment rate**), which looked at the number of unused (open) appointments. Most health centers (4/5) reported a decrease in their missed opportunities during the grant period (comparing summer 2013 with August 2015). The average rate was 13% in 2015, compared to 20% in 2013. By August 2015, three health centers were able to get their missed opportunities rate below 10%.



Another measure of productivity and efficiency was **cycle time**, which is the time from when a patient arrives for a clinic visit to when they conclude it. Four health centers improved average cycle time during the course of the grant. In 2015, the average cycle time was about 47 minutes, with a range between 40 and 61 minutes. Changes in cycle time for three health centers were modest (i.e., less than 10 minutes), but two health centers reported fairly significant decreases—one clinic decreased cycle time by 28 minutes, another by 13 minutes. Health centers that participated in Coleman's Rapid DPI interventions credited those efforts with decreases in cycle time. However, consistent decreases in this indicator were not observed among all health centers implementing Rapid DPI.

Spotlight on Chapa-De Indian Health: Efficiency in the face of increased demand

Demand for health services has increased in conjunction with the increased number of individuals covered by insurance with ACA and the expansion of Medi-Cal. Chapa-De has met this challenge by focusing on efficiency for the clinic overall, as well as on the integration of services—particularly primary care and behavioral health.

A key metric of efficiency is the rate of missed opportunities (i.e., unused appointment slots). During the grant—with the help of Coleman Associates—Chapa-De's missed opportunities dropped from 26% to less than 7%. They achieved this through active management of schedules and allowing for flexibility in schedules such that appointments can be made on the same day. A driving factor for missed opportunities is managing no-show rates:

> *"Our no-show rate is less than 10%, but that's where we've been for some time. It's not at 0%, but we're happy at under 10%. Our dental no-show is around single digits. That can be attributed to scheduling [management] and open access. Same day appointments are rarely missed. […] Providers are people who patients want to see, and we try not to make it too hard for them to do that."*

In addition to overall improvements in efficiency, Chapa-De implemented processes to improve the efficiency of the integration of primary care and behavioral health. This was achieved through three primary strategies:

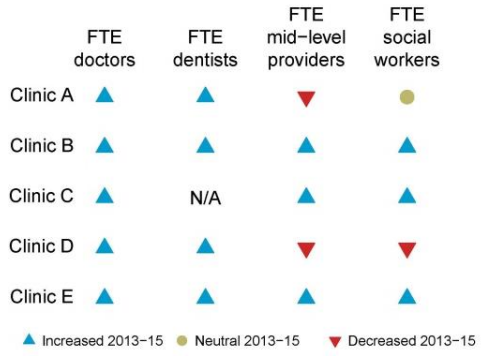
- Hiring medical assistants dedicated to the behavioral health department to aid with process efficiency; previously medical assistants had floated between behavioral health and primary care which made it difficult for them to manage different processes and teams.
- Enabling medical providers to screen a patient for behavioral health concerns and then book him/her on a therapist's schedule.
- Opening therapists schedules so they can come into the medical department when necessary.

Increasing Supply of Appointments

As stated, all health centers saw an influx of new patients during this grant period due to Medi-Cal expansion and changes in Covered California policies. Health centers identified these new patients as being more complex than current patients since many presented with multiple uncontrolled or untreated health conditions. Health center leaders indicated that increased efficiencies in operations alone were not adequate to meet and manage the increasing demand for primary care in the region.

Without compromising quality of care, the health centers' primary mechanisms for increasing supply were to add more examination rooms and hire more clinical staff. All grantees were constrained by the number of exam rooms and clinicians they had, and undertook a variety of measures to increase the amount of health care they could provide.

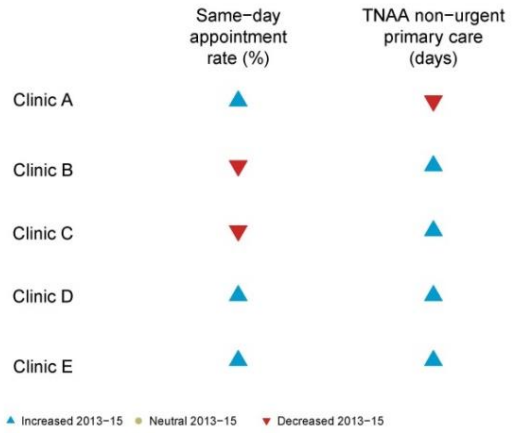
During the grant period, all but one of the health centers remodeled, reconfigured and/or opened a new clinic to increase available space for appointments; the remaining health center began developing a new site as part of its new strategic plan.



All grantees also responded to increasing demand by hiring new clinicians and dedicating resources provided through grant funding toward clinician recruitment with varying degrees of success. All grantees reported some increase in clinical staff between 2013 and 2015. All grantees increased the doctors' FTE at their clinic(s), with percentage change ranging from 27% to more than double (242%). Three grantees increased the FTE of mid-level providers. All four grantees with dental services increased the FTE of dentists and three of the five clinics increased FTE for social workers. The increases in behavioral health and dental staff reflect grantees' increased attention to integrated care delivery.

Two measures were used to assess performance related to increasing supply and improving access to appointments: the rate of **same day appointments** and the **third next available appointment (TNAA)** for non-urgent primary care.[2]

Allowing patients same-day access was important in the face of limited supply of clinical appointments. Rather than turning patients away, all health centers expanded open-access hours and allowed patients to come in without an appointment. While this may increase cycle times if more patients come in than cancel or do not show up, and may not allow the continuity of the patient seeing their normal primary care provider, it can reduce missed opportunities for care. All health centers expanded same day access to care; this was done through a combination of allowing walk-ins and holding same-day appointments. During this grant, three health centers reported increases in the percentage of same day appointments.



During the grant period, TNAA went up for four of the five health centers—ranging from same day access to 48 days (average was about 15 days). Only one of these health centers achieved same day access for

[2] Average length of time in days between the day a patient makes a request for an appointment with a physician and the third available appointment for a new patient physical, routine exam, or return visit exam. The "third next available" appointment is used rather than the "next available" appointment since it is a more sensitive reflection of true appointment availability. Source: www.ihi.org/resources/pages/measures/thirdnextavailableappointment.aspx

primary care. The increase in TNAA suggested that while efficiencies have increased, the supply of providers and appointments continued to be inadequate to meet the demand of patients in the region. Health centers reported that provider schedules fill consistently, leaving no availability for non-urgent primary care. This was most pronounced for the health centers that had limited success in recruiting new providers and could not significantly increase space.

Spotlight on WellSpace Health: Regional health center expansion

WellSpace Health has provided care for an increasing number of patients over the past few years. With ACA and the expansion of Medi-Cal, WellSpace Health has seen between 10,000 and 14,000 new patients each year. To serve this growing patient base, they have needed to increase the supply of appointments. They've done this in two ways: expansion of sites and additional staffing.

WellSpace Health opened a health center in Rancho Cordova in 2013, and another (San Juan) in 2014. These health centers brought WellSpace Health's total number of delivery sites to 17. Because the demand for services was so high, there were many changes and additions of health centers to meet that demand:

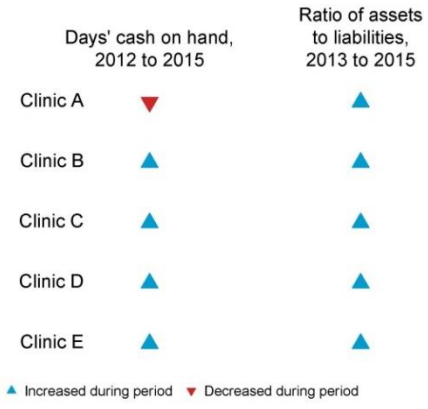
> *"In June [2015], we absorbed a women's health center program. We opened a school clinic – which is open to more than just students – at Hiram Johnson High School. We opened San Juan, and expanded pediatric care. We opened 7th and H in 2012. We are in the process of moving administration to a new site. [When we do that,] it'll double the exam room space in J Street, too."*

Staff recruitment has become paramount to the success of these health centers. Across the organization, WellSpace Health's staff numbers for full-time equivalent staff (FTE) grew by almost 40% to 315 FTE. When looking at WellSpace Health's health centers that are FQHCs, the numbers of physicians and dentists have grown by 42% and 33%, respectively. While WellSpace Health has increased the supply of appointments available to patients through larger numbers of sites and providers, the demand still outstrips the supply. Third Next Available Appointments for non-urgent primary care, mental health, and oral health have all been increasing due to high demand in the region.

Improving Governance and Operations

As grantees grew and built capacity, leadership responded by implementing changes in how their organizations were governed, bolstered strategic planning efforts, and provided staff training to empower staff and encourage dissemination of innovation throughout the organization.

All grantees saw an increase in the total number of staff between 2013 and 2015. Not only did the health centers hire more clinical staff (as discussed above), they increased **overall full-time equivalent** (FTE). The increases ranged from increasing FTE by 20% to more than doubling FTE during a two-year period, increasing staffing at all levels within the organization.

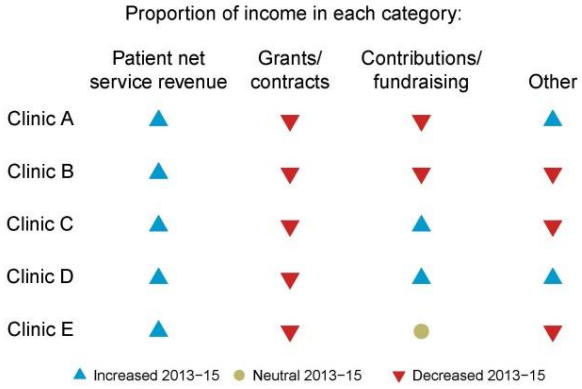


All five health centers also increased their financial stability over the last few years based on multiple measures. There was a wide range for the **number of days' cash on hand** that clinics had at the end of August 2015, from 40 to 417 days, reflecting the differences between these clinics and their

access to funding and revenue. While cash on hand varied by organizational size and structure, four of the five health centers more than doubled the days cash on hand between 2012 and 2015.

By 2014, the **ratio of assets to liabilities** for all health centers surpassed 1, indicating that all health centers had more assets than liabilities. In 2015, the assets to liabilities ratio for health centers ranged from 1.8 to 8.1, representing a stronger financial picture for all health centers compared to baseline, when the range was between 0.69 and 6.8.

Health centers also reported an **increase in patient net services revenue as a proportion of revenue between 2013 and 2015**. Conversely, the proportion of health centers' income that came from grants and contracts decreased. This was not necessarily reflective of a reduction in the total amount of grant funding, but indicated that a lower proportion of revenue came from grants, which could be the result of increasing patient net service revenue as a result of Medi-Cal expansion. Changes in contributions and fundraising were mixed across the cohort.



Spotlight on Cares Community Health: Governance and strategic planning

In 2014, the Center for AIDS Research, Education and Services—CARES—expanded its mission from a focus on HIV/AIDS care to an advanced primary care site and became Cares Community Health, first as an FQHC look-alike and then obtaining full FQHC status in 2015. This shift meant that Cares' population base would grow from an influx of predominantly non-HIV patients accessing care through Medi-Cal expansion. Leaders understood that the successful transition to an FQHC required a culture shift to improve efficiencies to meet the growing demand and to empower staff so that they embraced the changes while maintaining and improving care quality and safety.

Cares identified three objectives for their Sierra Health grant that would enable them to implement their strategic priorities in a timely way. These objectives included:

- Participation in Coleman Associates' DPI training program to help them establish processes to achieve greater efficiency and a set of metrics for performance-based reviews.
- Implementation of 'Just Culture' to empower staff to identify system failures that jeopardize patient safety or care without fear of blame; this model helped to operationalize Cares' focus on holistic health care and constant quality improvement.
- Certification as a PCMH, which further institutionalized the culture of serving the patients' needs holistically and empowering staff to work at the top of their license.

Their strategic plan identified DPI, Just Culture, and the pillars of the PCMH as the key mechanisms to operationalize their strategy to maintain or improve quality of care during expansion. The Sierra Health grant allowed them to prioritize these efforts and devote time and resources to ensure that they were implemented effectively.

Driving Quality with Data

Most of the grantees used the grant funds to invest in health information technology and data reporting capacity. Technological advances, particularly related to electronic health records (EHRs) and software overlays for the EHRs, increased health centers' capacity to use data to improve efficiency and quality. Population health management tools, such as i2i, allowed health centers to efficiently generate reports on operational and clinical quality metrics. These data reports were a key facilitator of data based-decision making.

> "We review our performance metrics monthly with providers. We also review it with a patient advisory committee, management, and at the board level. This year we are focusing on diabetes control, colorectal cancer screening, and blood pressure control. We are also making sure we focus on metrics that have changed since previous years; those might be a problem with documentation rather than treatment."
>
> —CMO, Grantee B

All grantees made progress on using data to inform decisions. Grantees focused on ensuring they had the right tools and reports in place to access data on specific metrics, reviewing and validating the data, and sharing the data with clinics, care teams, and individuals. More specifically, grantees:

- Improved their ability to create reports due to a better understanding of EHRs and registries, and in a few cases, hiring staff to work on improvements to data systems and automation of tasks.
- Increased the visibility of data—sharing data at various levels. Many grantees adopted provider-level data reports to share at monthly provider meetings to prompt improvement. Almost all grantees also reported frequent (e.g., weekly) quality assurance meetings to look at current projects and flag issues as they arise.

These improvements helped to increase availability of timely data, strengthen trust in the quality of data, and prompt discussions about implications and quality improvement. However, grantees were still at early stages in effectively using data to make improvements. The health centers were challenged by maximizing and effectively using the information technology systems they had access to. They were also working to hire data analytics staff, build staff's data literacy and shift clinic culture so that data were a driving force for informing improvement processes.

Spotlight on Winters Healthcare: Systems place a keen eye on data

In 2014, the team at Winters implemented EBO, a reporting tool integrated within its EHR, eClinicalWorks. This allows Winters to use real-time clinic patient data for quality assurance and improvement, as well as strategic planning and goal monitoring.

Winters was using these data to plan patients' visits and communicate across departments. Trained medical assistants and health coaches used data and EBO to create briefing documents for providers. Providers could then flag something for follow-up by the referral coordinator or other staff. Winters was in a unique position to maximize the use of their data because, in their words, "everyone uses data" –administrators, clinic staff, and the leadership team. Any staff member could make the case for changes to workflow or processes, as long as they used data to demonstrate a good reason for the change.

The data team at Winters developed systems capable of robust population health monitoring. Using EBO and other tools, the team monitored clinical quality, efficiency and program-specific data on a weekly basis. This system distinguished itself through four mechanisms:

1. The strength of the quality improvement team. The team had a deep understanding of the relevant topics and an ability to discuss multiple sides to an issue. For example, they examined the pros and cons of taking on a large employer's workers' compensation contract. They not only examined the potential administrative and financial risks, they also weighed the value to their community of taking it on. For each topic they discussed, they deliberated about both sides to the issue and then came to a decision together.
2. Continuous monitoring of quality improvement project metrics even after the projects end. If the team observed a "slip" in the numbers, they took immediate steps to address it.
3. Focused attention on process measures. Winters' quality assurance team monitored both process and outcome measures to look at the impact of their work. Process measures gave them more actionable outcomes in the short-term and allowed them to see the direct impact of any workflow changes.
4. All team members were encouraged to and did suggest improvements. Clinic leadership gave them the license to try almost any idea. In quality improvement meetings, when issues arose, they discussed the issue, the advantages and disadvantages of potential solutions, and came to a decision during the meeting before moving on.

Engaging Patients in Care

Throughout the program, health center leaders expressed concern that the drive to maximize productivity and efficiency would have a negative effect on quality and patient satisfaction. Many leaders expressed concerns that growth in small health centers might compromise aspects of the clinic culture that patients had come to trust and expect.

Many of the grantees took steps to assure their ability to provide high levels of patient service and maintain high levels of satisfaction. Grant-supported approaches varied among health centers. For example, grantees:

- Engaged volunteer patient liaisons and advocates to help patients in the waiting rooms
- Provided staff training, including implementing "Just Culture" and the Southcentral Alaska Foundation's "Nuka System of Care," designed to move the clinic beyond patient-centeredness to patient-driven care, enhanced staff engagement and improved quality

Grantees monitored these outcomes through annual Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys or at point of care through voluntary convenience surveys. Four health centers regularly reviewed patient satisfaction results to inform clinical practices; one of them used patient satisfaction as *the* essential measure of performance.

Another aspect of engaging patients in care was outreach to the community. All five health centers were engaged in targeted community outreach that aimed to ensure that community members were aware of their services. These outreach efforts were a response to health center leaders' observations that there were many newly covered individuals who had not yet established a medical home; one health center representative noted, *"if you build it, they will not come."* In many cases, new patients coming to the health centers after Medi-Cal expansion and ACA implementation were navigated to primary care services after a visit to the emergency room or an inpatient hospital stay. These newly insured patients had many unmet health and psychosocial needs. Many of the grantees recognized a need to reach patients earlier in their stage of disease—before they became so complex, which required more active community outreach.

Spotlight on Elica Health Centers: Active community outreach

In order to continue growing and serving the needs of the most vulnerable populations in the Sacramento region, Elica recognized the need to actively promote their services. Their philosophy of bringing medicine to the patient—through street medicine—was a strong start. By going to where the patients were, it filled the dual purpose of providing care while actively increasing visibility to potential patients. To support this effort, Elica hired a Public Relations (PR) consultant to help raise community awareness of Elica's services, particularly their new Arden-Arcade clinic. The PR consultant helped them with media outreach, and placed both stories and advertisements in the local news, radio, and billboards. Through targeted social media outreach, Elica was also able to reach individuals who were not reached through other methods.

Another key mechanism to raise Elica's profile in the community was to engage local politicians to proactively address any concerns they may have. For example, while in the process of renovating the clinic now in Arden-Arcade, a Sacramento County Supervisor voiced concerns that a new brick-and-mortar clinic would bring more homeless people to the area. Through discussion and engagement, Elica's leaders were able to work with the Supervisor to address her and her constituents' concerns. All of these methods together strengthened Elica's community presence.

IV. Program participation

In addition to the grant funding, the Clinic Capacity Building Program included opportunities for training, technical assistance, and peer exchange. In the design of these components, Sierra Health engaged key local health system partners (Dignity Health, Kaiser Permanente, Sutter Health, and UC Davis Health System) in reviewing clinic assessments and planning the direction of the training sessions. Health system partners were appreciative of this level of engagement and collaboration. This section of the report discusses the benefits and challenges of program participation as well as feedback about the program from both grantees and health system partners.

Benefits of program participation

Grantees appreciated Sierra Health's approach to the Clinic Capacity Building Program. Grantee representatives discussed how beneficial it was that the grant allowed them to work on capacity building projects that they selected. Additionally, grantees reported having positive relationships with Sierra Health staff and indicated that staff were responsive to feedback and asked the right questions about issues that were important to their health center.

The main benefits of the grant that health centers reported included: having dedicated time and resources to devote to capacity building; having a framework for improvement and time to develop a strategic plan for their health center; and having opportunities to participate in training and peer-learning.

Dedicated time and funds for capacity building projects: One of the main benefits of program participation was having dedicated time and resources to work on capacity building projects. Funds were used to support staff time to work on projects, hire staff and/or bring in outside consultants to help reach their capacity building goals, and invest in technology.

Dedicating staff time to focus on building capacity: All of the health centers mentioned that having dedicated staff time funded by the grant to focus on capacity building allowed them to do the necessary work to reach their goals. This included both time for staff to implement projects, as well as freed up time for administrators to develop strategic plans for the health centers' improvement efforts. Additionally, the grant enabled the health centers to send their staff to trainings that bolstered their quality improvement and capacity building projects.

> "The funding freed up administrators for some time to focus on strategizing and other things they don't normally have time for."
>
> —Clinic leadership, Grantee E

Hiring staff and consultants to improve capacity and efficiency: Most of the grantees used the grant to hire additional staff and/or consultants to help with improvement efforts. Three of the health centers engaged Coleman Associates to work on Rapid DPI. The consultants worked on-site with the clinics to improve team-based care and clinic efficiencies. At some sites,

> "When it came to using Coleman to increase our practice, we needed [the growth consulting] badly ...if Sierra Health Foundation could do it all over, it would have been really great to have a consulting team assigned to us...match the weaknesses in our assessments to consultants' strengths."
>
> – Administrator, Grantee B

consultants were also brought in to help with internal communication and leadership skill building. Grantees also used resources to expand their staff in key areas of needed capacity. This included dental support, nurse addictions specialists, and social workers, among others who will be sustained by increased patient service revenue.

***Providing on-site staff trainings*:** Four health centers used grant funds to provide trainings to their staff on-site. The type of training varied, but much of the content focused on training mid-level providers and on integrating care, such as training on health coaching. One grantee used funds to send staff to outside training on relationship-based care.

> "To implement this well, we need to have everyone go through training, so we split the staff and one half goes, then the other. The grant offsets the loss of revenue."
>
> —CEO, Grantee A

Implement technological improvements: A key part of improving clinic quality is being able to track patients and their care. There are tools that health centers can use to help them achieve this goal. For example, two grantees implemented population management systems, i2i, using grant funds. Another grantee purchased an add-on to their EHR, which provides reminders to the provider about patients' care needs (e.g., screenings, tests, prescriptions, etc.).

Framework for projects on efficiency and quality improvement: In addition to the specific contributions that the funding provided, the grant provided structure for the capacity building and quality improvement projects that the health centers wanted to implement. Three health centers mentioned that the grant helped their teams establish a process and structure for quality improvement projects. Additionally, some of the health centers stated that the grant was beneficial to help them develop or strengthen their strategic plans.

> "We wrote these elements into the grant so we would be accountable to someone to get them done."
>
> —Administrator, Grantee B

Forums for learning and peer networking through the Board receptions, CEO luncheons, and Safety Net Learning Institute: The Safety Net Learning Institute (SNLI), receptions for health centers' Board of Directors, and luncheons for health centers' CEOs were forums that brought together staff and leadership from community health centers across the Sacramento region. Health system representatives indicated that through these activities, Sierra Health had established itself as an effective and credible convener.

The Safety Net Learning Institute sessions were informative: In addition to the five grantees, the SNLI sessions had additional participation from five other health centers in the greater Sacramento region. The purpose of the SNLI was to provide a forum for health centers to learn about a variety of topics that would provide a foundation for quality improvement and capacity building work. The health centers appreciated

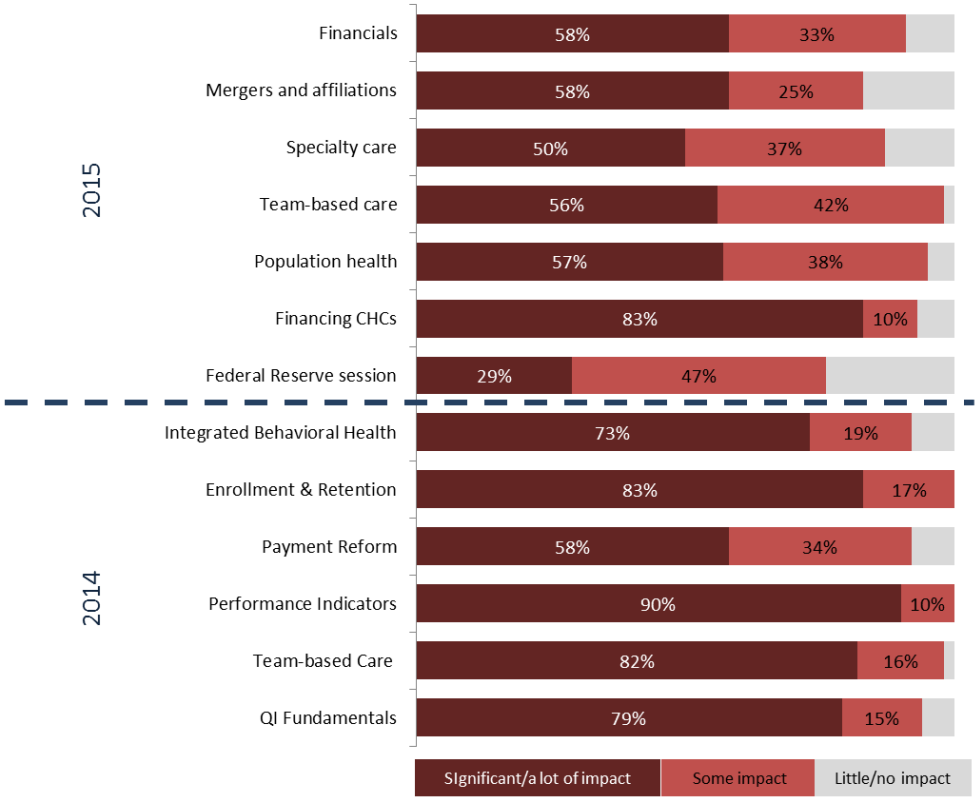
> "The [SNLI] sessions I've attended have been very helpful – one of the best things to come out of the grant."
>
> —CEO, Grantee E

> "Amazing people presented at the SNLI sessions … the experts were great."
>
> —CEO, Grantee A

the flexibility to determine which staff would benefit most from attending these sessions. Representatives from all of the grantees mentioned that they thought the SNLI sessions were informative and the speakers were of high caliber.

After each session, participants were asked to provide feedback on the session. The percent of participants who responded that a given session had at least some impact on their work ranged between 92% and 100% in 2014 and between 76% and 98% in 2015 (see figure below). This indicated an overall positive view of the sessions across both years. The sessions that were most frequently rated as having had a significant impact (over 80% of respondents) included: the 2014 sessions on performance indicators, enrollment and retention and team-based care principles, and the 2015 session on financing community health centers.

Impact of SNLI sessions in 2014 and 2015 (% of respondents)



Respondents also rated the quality of the content and presentation. The vast majority of respondents said that the quality of discussion during the sessions was high. Overall, the amount of participant involvement was rated as "about right." For each session, the presentations were also rated on their style, content, and materials; in all of these areas, the presentations were viewed positively in both years.

Health system partners indicated that the SNLI sessions exposed health centers to concrete and useful topics; one health system partner noted that *"since [the health centers were new] in the world of clinic transformation that [engaging in regional and state level conversations] was important and Sierra Health Foundation facilitated that."*

The Safety Net Learning Institute promoted collaboration: The health system representatives indicated that the SNLI helped promote collaboration among community health centers and got people talking about the issues and potential next steps to improve access and quality of care in the region. All grantee leaders agreed that the SNLI sessions were a great opportunity to network and share ideas.

> "It's good to hear from our colleagues and competitors about what they are doing […] and the different strategies people have taken."
>
> —Clinic Leadership, Grantee E

CEO luncheons provided forums for discussions: The CEO luncheons were opportunities to create a leadership community among safety-net clinic leadership. The discussions at the luncheons were focused on strategic questions that influenced safety net providers in the region. The CEOs' opinions of the CEO luncheons were more mixed than feedback on the SNLI. The CEOs discussed the benefits of dialogue with colleagues who are facing similar issues and have approached solving those issues in different ways. To build on the conversations started in the CEO luncheons, some of the CEOs called for bolder, more candid conversations among the leaders on matters of shared importance and universal challenges.

> "The roundtable [at the CEO luncheon] was a helpful exchange of challenges and ideas."
>
> —CEO, Grantee A

Board receptions exposed members to what was going on in the safety net community*:* The board receptions were viewed positively by health center leadership. They mentioned that it was useful for the board members to gain familiarity with how the health centers' programs connect to each other. Leaders from three health centers said that the board receptions were not as helpful for them as for their board members. One CEO said: *"I went to the Board Reception with a community board member. They had great speakers and were really fun. The board member loved it. The receptions were big picture and forward thinking; it was good for the board members to see the journey that FQHCs are going on. […] Our board member who went said that it made her feel more educated and that it was information that was not often brought to them as a board."*

Challenges with program participation

The grantees were also asked what, if any, challenges they faced as a result of participating in the program. The main challenges that grantees reported were competing time demands, coinciding capacity-building projects, misalignment of SNLI sessions with health center needs, and the short time frame of the grant to implement projects.

> "Trying to meet the demands of the grant, the CEO meetings and others, felt a bit like a burden because we also have to meet very immediate needs at the clinic."
>
> —Clinic Leadership, Grantee E

Burden of time: While the SNLI sessions, CEO luncheons, and Board receptions were informative, most of those interviewed expressed that it was difficult to both attend the sessions and continue to meet their health center's needs. As previously discussed, the grant helped pay for staff's time to attend these sessions, but it did not provide funding for all relevant staff to attend or reduce the demand for clinic services or the health centers' workloads. While the CEO luncheons were difficult for some leaders to attend, one health center leader indicated that having more frequent meetings would enable CEOs to build trust, rapport and comfort discussing the "big issues."

Coinciding capacity-building projects: During the time of the program, Kaiser Permanente Community Benefit provided money and technical assistance to the same five health centers to increase quality improvement capacity. Kaiser Permanente provided grants to the health centers to participate in Building Clinic Capacity for Quality (BCCQ), a program of Community Partners. BCCQ worked with health centers on specific quality improvement projects. The general feedback was that there were a lot of synergies between the two efforts and that the work overlapped to some extent, which worked well for some of the health centers. However, three health centers found it difficult to manage and fully participate in the requirements of both grants at the same time. Representatives from Kaiser Permanente also noted that the coordination between grant programs could have been better to reduce burden on the health centers.

Short grant timeframe: Given the extent of changes and growth that the health centers were experiencing, a two-year grant felt "really tight" for a few health centers. One health center stated the grant would have been *"better suited to a longer runway."* Many of the challenges the health centers were facing are long-term, systemic challenges that need continued attention beyond the life of the grant.

Reflections on participation

When reflecting on program participation, grantees had a number of suggestions for strengthening the technical assistance offered in future programs. Their recommendations were centered on their experience participating in the Safety Net Learning Institute.

Alignment of session topics and technical assistance with individual clinic needs: While the grantees and health system partners indicated that the topics were relevant and useful, both grantees and health system partners noted that the topics "*couldn't be perfect for all of the clinics simultaneously*" given the different needs and levels of sophistication of the health centers. One grantee leader suggested that the training and technical assistance could have been more closely tied to needs identified in clinic assessments and visits. Additionally, grantees said that it would have been useful to have a "menu" of available consultants across a variety of topics so that they could see what was available. They suggested that marrying a list of available resources with an assessment to prioritize individual grantee needs would yield more targeted training and technical assistance for a greater impact on the health centers.

Advanced scheduling and communication: A few grantees mentioned that they would have liked to have more advanced notice about the schedule for and topics of the SNLI sessions. One grantee said, "*It did not seem like [TA resources] were planned in advance*." Another grantee said that they didn't receive notice of events far enough in advance, which made it difficult to bring the relevant individuals or teams to an event.

Additional topics of interest: While grantees felt the topics covered were useful, they noted several areas where additional assistance would have been helpful. This included discussions on how to problem solve issues within the health center, promote team work and collaboration, and improve intra-clinic communications. They see these topics as relevant to all health centers in the cohort, regardless of the health centers' sophistication and stage of development.

Beyond theory to operationalization: Grantees reported challenges in making the information learned actionable. The participants had a desire to take the learnings back to their clinics and apply them, but there were many comments about the topics being a little "superficial," needing to move from theory to mechanics, and the desire for case examples of how the theory was applied. One health system partner noted that they interpreted the goal of the SNLI as exposure to topics without the expectation that the session alone would move the health centers to immediate action. Health system representatives also noted that the health centers didn't always have the right people in the room to actually be able to apply the information from the sessions.

V. Encountering and responding to challenges

Grantee leadership demonstrated commitment to growth and sustainability, while trying to address challenges of aligning workforce, patient demand, and infrastructure limitations. The dynamics of trying to align supply and demand was further complicated by the constraints of unfamiliar and often unresponsive regulatory processes. Although all grantees increased their capacity and are serving greater numbers of patients, grantee leaders noted their organizations faced myriad challenges in the process. Challenges included:

> "We are moving faster than we can keep up with."
>
> – CMO, Grantee C

- Recruiting and retaining a qualified workforce
- Managing complex new patients
- Managing and leading change
- Navigating uncharted territory and regulatory roadblocks
- Remodeling and expanding clinic space
- Adopting new technology
- Leveraging opportunities for collaboration

All five grantees reported at least some challenge related to each of the themes. These challenges were often related and a competitive culture among some of the health centers intensified some of these challenges.

Recruiting and retaining a qualified workforce

> "We don't have the staff capacity. We have the physical capacity in our facilities. We have the IT capacity in all our exam rooms—thanks to Sierra Health Foundation—but we need more staff."
>
> – CEO, Grantee C

The shortage of primary care providers is especially hard-felt in community health centers. Earlier in the initiative, grantees talked about difficulties with retention and turnover—due to rapid growth and constant change—and the challenge with replacing staff. At the end of the grant, grantees reported fewer concerns about *retaining* existing providers. They indicated that the extent of change and growth had slowed and staff that remained were committed to the organization. However, health centers were still experiencing workforce shortages and discussed the challenges of recruiting new staff to meet growing demand. Several factors contributed to the workforce shortages experienced by these health centers:

- High levels of demand for clinical and operations staff in the region were creating an overall workforce shortage.
- Given the workforce shortage, community health centers had more difficulty recruiting because they could not offer competitive pay and two health centers were located in rural areas.
- The health centers needed experienced providers to meet the needs of complex patients, so hiring recent graduates and mid-level providers alone was not sufficient to meet care needs.
- The shift to integrated and team-based care increased the need for a diverse range of positions in the health center. These positions were often new to the health centers, so they were looking for experienced staff, which was difficult to find—in particular, many health centers were in need of experienced data analytic staff.

Managing new and complex patients

The ACA and Medi-Cal expansion resulted in people having access to care who previously had not; many of these patients had unmet health care needs that were extensive and complex. Many of the grantees noted an increase in behavioral health and substance abuse/pain management needs with physical health care needs. Meeting the needs of complex patients was resource intensive and these health centers were confronted with a high volume of complex patients while also having workforce shortages, as discussed above.

The challenges grantees discussed when talking about complex new patients included:

- ***Facilitating access to specialty care:*** Accessing specialty care for safety net populations was difficult, particularly in the Sacramento region where there is not a public hospital system (which in many counties in California is the primary provider of specialty care for the safety net). Available specialty care resources were limited and, with the ACA, specialty networks that accepted Medi-Cal changed. Determining where to refer patients for specialty needs was time consuming for health centers to navigate.
- ***Providing/securing wrap-around services:*** Providing services like navigation, care coordination, and health coaching to patients was an important part of care delivery—particularly for complex patients. However, time spent providing these services was not reimbursable, so the health centers had to build it into operational costs in other ways.
- ***Coordinating care between systems:*** While health centers were working to integrate care within the clinics, communication and information exchange—the feedback loop—between health centers and external care providers continued to be an inefficient, manual process (e.g., getting information back to primary care from specialists and hospitals)
- ***Managing competing priorities of clinic efficiency and meeting needs of complex patients:*** As one grantee explained, *"We are getting complex patients, and the intakes take forever, which works against our capacity and efficiency goals."*

Managing and leading change

"There is huge resistance to change. We need behavioral change to happen for our providers – they need to believe that these changes will work and that they and their patients will benefit. They need to switch their mindset and have to let go of the way things used to be done."

– CEO, Grantee E

As discussed in key accomplishments, grantees undertook broad measures to adapt to the health care environment and implemented significant systems changes. Not surprisingly, interviews revealed various levels of resistance to changes within the health centers. As one grantee explained, *"With every change there is a rule of thirds. The first third will jump at the change and go for it. Another third will have some doubts and eventually get on-board. The last third will just quit. When we brought in electronic health records, a third of our doctors said they were going to retire."*

The need for change to happen rapidly added stress to the health center and to individual staff. Rapid change also put pressure on communication systems and practices within the health centers. Health center leaders recognized that the extent of growth and change called for more deliberate and inclusive communication strategies to maintain cohesion and engagement. They noted that it was particularly important for leaders to articulate why changes were taking place rather than just what changes were occurring.

Certain changes raised more resistance than others. Grantees noted intense resistance around new technology and systems and the associated modifications and "patches" to the system. Some health center leaders noted that staff perceived the modifications as an indicator that the system was not working rather than as expected updates to the system. This resistance to change within the technology systems led to reticent providers pushing back on necessary technological changes.

The other key challenge was changes to incentives and expectations. Health center leaders noted that there was a tension between efforts to promote quality and efficiency. Many clinics articulated a need to move towards a performance-based incentive structure while also trying to maximize the use of existing capacity. One health center CEO explained the tension: *"Providers are interested in patient-centered care. Operationally, efficiency sounds good, but providers are interested in quality and safety."*

Navigating uncharted territory and regulatory roadblocks

The path towards increased capacity involved implementing new systems, and required knowledge about specific regulatory and certification processes with which many leaders had little previous experience. The process of getting approval, certification or appropriate permits often delayed health center initiatives or prevented them from operating as they had hoped. This particularly applied to adding space (i.e., permits, regulations), pharmacy/filling prescriptions, and complying with reporting requirements as new FQHCs. In some instances, health centers that had already accomplished what others sought to do lent advice and assistance.

> "[Would you know} …how to select a building, measure the costs of renovating it to [comply with] Title 24, with its 12 sections and 100 manuals? If you add an elevator then you need to also comply with Title 12 and OSPD 3."
>
> —CEO, Grantee C

Remodeling and expanding clinic space

All grantees opened or were developing new and larger clinics to meet demand. Challenges associated with limitations of existing space and opening new clinic spaces were common.

To address challenges related to space, most health centers first capitalized on modifying and remodeling existing clinic footprints, but eventually maximized the use of their existing space and began looking at additional space. As one CEO explained, *"We added two exam rooms in the basement, but we are running out of space."*

> "Trying to develop new health centers is one of the most difficult things we do…differing thoughts about how to expand, talking to architects, running into state regulations…"
>
> —CEO, Grantee D

Once health centers began to look at expanding space, they ran into regulatory challenges—negotiating and complying with regulatory rules—as was mentioned above. Taking into account the patients' care needs and how care will need to be structured complicates design of these new spaces. Health centers were trying to anticipate future needs by building out space to accommodate new models of care before fully implementing changes in how care was delivered. Clinic space needed to be built to facilitate team-based care and alternative visits (e.g., group visits) as well as to have sufficient space for clinic services and operations, such as medical exam rooms, counseling spaces, dental operatories, pharmacy and call centers.

Adopting new technology

Grantees reported the most difficult shift in clinical practice was the implementation of EHRs and other health information technology. They reported these changes impacted their health centers at all levels—from clinic workflow to financial management. These systems are complicated and grantees recognized the need to have in-house expertise to maximize system efficiency and data utilization. However, they indicated that recruiting qualified data analytics and IT staff was a challenge.

> "There's a need for more internal knowledge of the EHR and trainers for it. We now have two clinical application coordinators that help with the patches to the system. We meet weekly to work through issues, and the coordinators meet one-on-one with providers for change management."
>
> —COO, Grantee E

More specifically, grantees reported challenges related to implementing new systems including technical challenges like learning new platforms, determining reporting capabilities, and negotiating data ownership and access. Additionally, there were challenges related to integrating new technology into clinic workflow and providing adequate training for staff. Leaders stated that, for some staff, the complexity of the systems and the learning curve to become a proficient user were cumbersome and time consuming.

Leveraging opportunities for collaboration

Within the region, grantees and health system representatives indicated that there were not effective vehicles for collaboration among community health centers. The community health centers in the Sacramento region—including but not exclusive to the five funded through this program—shared a geographical region, but have relatively disparate patient populations and collaboration among them has been limited.

There are two membership groups that some of the health centers belong to—the Capitol Health Network, which is an affiliation of health centers, local hospital systems and other social service agencies, and the Central Valley Health Network, which is a clinic consortia serving a large geographic area. Neither entity was identified as effectively promoting or facilitating collaboration among the safety net providers in the Sacramento region.

Without a meaningful network for the community health centers, there has not been a forum for collaboration, joint planning or shared health initiatives to meet the health care needs of the Sacramento region. This resulted in an environment where the health centers operated ostensibly as competitors, rather than collaborators, and any community initiatives were undertaken individually, or through limited partnerships between a clinic and health system partner. One health system representative explained, *"[The environment] is every clinic for themselves, not that they want to be…but there is no neutral partner to help facilitate cooperation."* The lack of a neutral convener has prevented the safety net system from coming together and creating a longer term vision for the region. Another health system representative stated that *"Nothing is going to work if we continue these one-off relationships; we can't continue to piecemeal [an approach to meeting demand]…it has to be all of the [clinics], or at least the strongest clinics coming together…larger collaboration will move us to the next level."*

VI. Considerations for Sacramento's safety net

The grantees were rapidly growing health centers which were adapting in order to meet the growing demand for health care services. The Sierra Health Foundation grant provided these health centers with general operating-like support to invest in strengthening their infrastructure to implement ways of delivering care differently, improving clinic efficiency, increasing supply of appointments, strengthening governance and operations, increasing data capacity and utilization to use data for quality improvement, and engaging patients in their care.

> "In many ways, Sierra Health is playing the role of a consortium, and good for them for taking it on. But they aren't going to do it forever. We need to continue to build on that. I'm not sure that Sierra Health has seen the benefit of their role as much as we have."
>
> - Health system representative

In addition to these individual grants, Sierra Health convened community health centers in the Sacramento region (grantees and unfunded health centers) to participate in the Safety Net Learning Institute, which exposed these health centers to state, regional and national experts on topics relevant to the health centers' capacity-building work. These sessions—along with CEO luncheons and Board receptions, also sponsored by Sierra Health—provided forums for peer exchange and learning, and were one of few opportunities for health centers to come together to share ideas and problem solve. Representatives from the grantees and health systems reported that sponsoring these sessions had **established Sierra Health as an effective convener** and there was uncertainty about who would be able to fill that role after the Sierra Health investment ended.

In Sacramento, the demand for health care services continued to outweigh supply. Despite the significant efforts, grantee and health system representatives reported that patients were still not able to get the care they needed. Health centers were unable to meet the demand by maximizing existing capacity—they needed to expand and grow. The most significant challenge to meeting demand—identified by grantees and the health system representatives—was the lack of collaboration in the region. Both grantees and health systems recognized that **health centers needed a sustainable support structure and a neutral convener to promote collaboration**. A consortium or convener would be beneficial to:

- Provide leadership and a vision for a regional safety net system
- Provide forums for peer exchange and collaboration
- Create an infrastructure to support ongoing capacity building at the clinics
- Support and develop clinic leadership

The health system representatives indicated a need for a clinic consortium to support the work of the health centers, but also indicated that the health centers need to own it and drive it—*"commitment has to come from the clinics."*

The health systems—Dignity Health, Kaiser Permanente, Sutter Health, and UC Davis Health System—saw themselves as partners in strengthening the safety net; however, they all played slightly different roles and had different interests and processes for supporting the health centers. There was some coordination among health systems and other local funders—like Sierra Health—but health system representatives reported that consistent and reliable communication among funders was lacking and that the investments were a piecemeal approach. Health systems recognized that the **region would**

benefit from a more coordinated funding approach, rather than each health system and funder determining their strategy individually.

Generally the health systems have provided more funding to larger, more "full service" and established safety net clinics. They were looking for health centers that have capacity to effectively partner—that means health centers that have financial stability, positive reputation, strong leadership and transparency. However, they recognized that it's critical for community health centers and health systems to partner to meet the health care needs of the safety net and see more potential for collaboration as the health centers mature. The health systems saw Sierra Health as a key player in the region and an important partner to continue strengthening the capacity of the safety net.

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*This report was prepared by the **Center for Community Health and Evaluation** (CCHE), which is part of Group Health Research Institute based in Seattle, Washington. CCHE designs and evaluates health-related programs across the United States. We partner with foundations, nonprofits, and government agencies to help assess the impact of community investments and figure out what works to improve health. For more information about CCHE, visit our website: www.cche.org.*

Appendix: Doing care differently grantee spotlights

Spotlight on Cares Community Health: Contemplating a campus of care

From where he sits, *"…the days of the corner medical practice are over,"* says the acting CEO for Cares Community Health. Delivering care differently at Cares Community Health means a lot more than establishing Cares as a PCMH, expanding the clinic space and pharmacy, adding mobile dental services to complement behavioral health services already in place, deploying Coleman's DPI, and reaching out to non-HIV patients—all of which they have done in the past two years. It means something even more grand: *"We're trying to build a campus."*

When plans are fully realized, Cares' original facility, a converted bank in Sacramento's vibrant mid-town, may become the cornerstone of a not-for-profit health care complex occupying a full city block with separate facilities for primary care, women's health, dental services, mental health counseling, a Federally-subsidized pharmacy, and space for community and education programs. Cares has already acquired and remodeled a second building. The term 'campus' is appropriate, as Cares would expand its current role as a community training site for internal medicine residents at UC Davis to a broader range of medical residents, students and fellows. Offering such a comprehensive range of health services may provide opportunities for Cares to become a community training site for other health professions including nursing, social work, pharmacy and dentistry.

With its founding as a community-based HIV clinic in 1989, Cares established itself as the leading source of HIV treatment and care. Through their work with the HIV community of patients and providers they built a sophisticated and effective system of care for HIV+ individuals, and that won't change. According to the clinic's manager of programs, *"We won't change the way we care for HIV patients. Instead, we will adapt that model of comprehensive and compassionate care for the community. We want to export what we've done for HIV care to the broader community and their complex needs."*

Spotlight on Chapa-De Indian Health: A new day dawning

It is a new day at Chapa-De, where doing care differently took on special meaning and significance. Chapa-De is jointly designated as an Indian Health Service clinic and FQHC look-alike in the foothills of the Sierra Nevada Mountains east of the Sacramento Valley. For many years the clinic preserved the pace and tradition of providing health care to the local American Indian population as it always had. With the concurrent decision by the county health department clinic to stop accepting new patients and the implementation of the Affordable Care Act, things changed dramatically and quickly for Chapa-De and its leaders, providers, staff and patients.

Chapa-De transformed its physical space undergoing a major remodel completed early in 2015. The transformation was not only physical. Chapa-De leadership embraced radical change and with this grant implemented a conversion to an accredited PCMH offering primary medical care, behavioral health services, nutrition and health education, pediatrics, women's health services, dental care, orthodontia, psychiatry, optometry, and pharmacy services. Many of these services expanded under the Sierra Health grant. With grant funding, Chapa-De explored DPI work with Coleman Associates altering how they delivered care and changing how the clinic went about its work.

Rapid transformation against a history of limited and slow change was not easy. Providers and staff, disoriented by the changes in facilities, patients and processes, sought the familiar to provide stability; they looked to the old ways and challenged the new. With so many things being done differently, systems of care needed to be integrated and realigned. Communicating change of this scale with a larger, more diverse and less cohesive staff presented new challenges leadership had not traditionally faced and resulted in some growing pains, which the clinic was grappling with at the time of this report.

Spotlight on Elica Health Centers: Providers to the people

Elica brought providers to the people, literally. Elica's founding CEO described her approach to delivering care differently: "*We had a huge demand [for services] when we went to people in their own neighborhoods… When we go to them, we can assess the social determinants first-hand and treat them with that in mind. We build trust to where they will eventually come to the clinic.*" Running out of clinic space and committed to the most vulnerable populations, Elica embraced a three-phase street medicine program to provide care while adding space in their brick-and-mortar facilities and opening a third clinic site.

Elica providers and social workers set out along the riverbanks and levies with backpacks and 5-gallon buckets of supplies practicing the most rudimentary type of care: backpack medicine. On foot they encountered chronically homeless people in an initial outreach; they met the patient wherever they were—in a tent on the banks of the American River, in a homeless encampment on a slough, or at a residence motel or shelter—and assessed their needs and offered care. Additionally, and more visibly, Elica provided "pop-up" clinic services at community events and at local churches, which helped it establish its identity in the community while providing initial preliminary care encounters, screening and testing, verifying insurance eligibility, and building rapport with community members and cultural leaders. The final tier was Elica's "Health on Wheels" mobile clinic. The clinic visited schools through an arrangement with San Juan Unified School District. This program improved access to medical care for youth and their families and greatly expanded the range and complexity of care Elica could provide outside the walls of its three clinics.

Delivering care differently for Elica meant disrupting and innovating from within. Elica's COO explained, "*What could be more disruptive and innovative than Health on Wheels? ... Elica would like to have ten mobile health units on the streets*." and is capable of providing as much continuity of care as can be provided for people already living on the fringe.

Spotlight on WellSpace Health: Creating the regional health home

Many of WellSpace Health's patients were complex and came to the health center with chronic illnesses and underlying mental health issues and chemical dependency, which made patient management and treatment more difficult. WellSpace Health made it their business to address all of the struggles its clients faced, whether managing depression in the face of chronic illness, or transitioning from hospital to respite to home and primary care. Improving health center capacity at WellSpace Health involved more than opening new health centers.

WellSpace Health focused on meeting needs across the metropolitan region. In 2015, six primary care sites received PCMH certification, signaling to the community that WellSpace Health was delivering care differently. Twelve regionally-distributed health centers integrated medical and behavioral health; WellSpace Health included evidence-based depression screening at intake and behavioral health care was provided within the patient visit. Some sites offered pediatric dental care, women's health services, psychiatry and substance abuse counseling. WellSpace Health also operated rehabilitation treatment centers and community treatment sites and services.

Keeping the sites integrated and coordinated, WellSpace Health upgraded tele-communications, added a call center, and relied on a well-tuned cadre of regional managers to coordinate service innovations across the health centers. Doing care differently at WellSpace Health meant that: operational innovations could be launched at any health center, within a quality improvement—"Plan-Do-Study-Act"—framework, and would eventually be disseminated throughout WellSpace Health.

Spotlight on Winters Healthcare: Patient satisfaction above all

Winters Healthcare understood that successful strategies to provide integrated care to the sparse rural communities of western Yolo County were going to be different. After investigating several models, they embraced a system of care created to provide access to medical, dental, behavioral, traditional and health care support services by building trusting relationships: the Nuka System of Care, developed by Alaska's Southcentral Foundation and subsequently endorsed by the Institute for Healthcare Improvement (IHI) and others at the forefront of transformative health care.

Nuka, a word of many meanings—honor, strength, big living things, dignity, love, generosity and support—strives to build a holistic system of care around the patient and engages every member of the organization, from the janitor to the CEO. Within Nuka, patients are called "customer-owners" and interact as equals with all members of the care team. They are at the center of every system created to support them and honor them as owners of their health, wellness and the organization. This is the fundamental principle of customer ownership. The model is also distinguished by the primacy of relationship, meaning the relationship between the primary care team and the customer-owner is the most important means to affect change. This extends from the customer-owner throughout the organization, and requires whole system transformation beyond the delivery of care including facilities, workforce development, governance, compliance, human resources, and finance. To support this transformation, all members of the Winters' team received communication training to improve and prioritize patient satisfaction.

To grow and be distinguished in this community of less than 10,000 people, Winters Healthcare embraced not a return on investment, but a return on relationships.